Authorization for Release of Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The Department of Employee Insurance only maintains demographic protected health information which includes enrollment, eligibility, family dependents and qualifying event information. The third-party claims administrator (Humana) and third-party pharmacy benefits manager (Express Scripts) maintain medical condition and treatment protected health information. The third-party administrator will have a separate HIPAA Authorization and Release Form.

Members name: _____ID Number:_____

Persons/organizations authorized to provide the information:_____
_____
_____

Persons/organizations authorized to receive the information: _____
_____
_____

Specific description of information to be used or disclosed (including date(s)):
_____
_____
_____

Specific purpose of the disclosure:
_____

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
No_____ Yes (describe)_____
_____

This authorization will expire _____(indicate date, or an event relating to you personally or to the purpose of the authorization).

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

• I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.

• I may see and copy the information described on this form if I ask for it.

• I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

• The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Member or Member's Representative

_____ _____

Signature of member or member's representative **Date**

(Form MUST be completed before signing.)

Printed name of the member's personal representative:

_____

Relationship to the member, including authority for status as representative:

_____

_____

Signature

_____

Printed

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